

STARTING POINT Child Care Resource and Referral Family Child Care Home Update Form

Provider: _____
(First Name) *(Last Name)*

Address: _____

City: _____ **Zip:** _____ **County:** _____

Mailing Address: _____

City: _____ **Zip:** _____ **County:** _____

Primary Phone: () _____ **ext.** **Secondary Phone:** () _____ **ext.**

Fax #: () _____ **E-Mail Address:** _____

Website: _____

Update Method: **Phone** **Fax** **Postal Mail** **E-Mail**

Accepted Age Range: **From:** [] **Years** [] **Months** [] **Weeks**
To: [] **Years** [] **Months** [] **Weeks**

Transportation: To/From Home To/From School
 Walking Distance to School Near Public Transportation

Which Age Groups Do You Transport? Infants (Newborns-18mos) Toddlers (18mos-36mos)
 Preschoolers(3yrs-5yrs not in Kindergarten) School-Agers (5yrs in Kindergarten-14yrs)

Family Child Care Setting: House Townhouse Duplex
 Apartment Mobile Home

Languages: English Spanish Asian American Sign Language
 Hebrew Russian Arabic Other: _____

Accreditation/ Education: High School Workshops/Trainings CDA NAFCC
 Associates Degree (Child Related) Associates Degree (Other)
 Bachelors Degree (Child Related) Bachelors Degree (Other)
 Masters Degree (Child Related) Masters Degree (Other)

Policies: Child Must Be Toilet Trained Written Contract Interview Required
 Written Polices Has Back-up Provider Provide Sick Child Care

****Required Fields, Please Fill Out Completely**

Days	Start Time	End Time	Accepts Children		
<input type="checkbox"/> Monday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Both
<input type="checkbox"/> Tuesday	<input type="text"/>	<input type="text"/>	Year Schedule		
<input type="checkbox"/> Wednesday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full Year	<input type="checkbox"/> School Year	<input type="checkbox"/> Summer Only
<input type="checkbox"/> Thursday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Drop In <input type="checkbox"/> Temp/Emergency Care		
<input type="checkbox"/> Friday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Before School	<input type="checkbox"/> After School	
<input type="checkbox"/> Saturday	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Rotating Schedule	<input type="checkbox"/> 24-Hour	<input type="checkbox"/> Open Holidays
<input type="checkbox"/> Sunday	<input type="text"/>	<input type="text"/>			
Scheduling Flexibility Comments:					
<hr/>					
<hr/>					
<hr/>					

****Rates: (**Required Fields, Please Fill Out Completely)**

Age Groups	Weekly Full-Time	Daily Full-Time	Weekly Part-Time	Daily Part-Time	Hourly
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Special Rates:	Before School	After School	Before and After Full-Time	Summer/Break
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Fees: Registration/Application Fee Deposit

Comments: _____

Financial Assistance: Publicly Funded Child Care Sliding Fee Scale
 Multi-child Discount

****Capacity By Age Groups: (**Required Fields, Please Fill Out Completely)**

1st Shift		2nd Shift		3rd Shift	
Number Enrolled	Vacancies	Number Enrolled	Vacancies	Number Enrolled	Vacancies
Infant	<input type="text"/>	<input type="text"/>	<input type="text"/>	Infant	<input type="text"/>
Toddler	<input type="text"/>	<input type="text"/>	<input type="text"/>	Toddler	<input type="text"/>
Preschool	<input type="text"/>	<input type="text"/>	<input type="text"/>	Preschool	<input type="text"/>
School Age	<input type="text"/>	<input type="text"/>	<input type="text"/>	School Age	<input type="text"/>

****Required Fields, Please Fill Out Completely**

Special Needs: Number of children with special needs you are willing to serve?
 Number of children with special needs currently being served?

Please list the specific special needs of children. For each of the following, list how many children have a specific need. (I.e. Asthma 3, Autism 4, etc.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Emotional/Behavioral |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hearing/Speech | <input type="checkbox"/> MR/DD |
| <input type="checkbox"/> Physical Mobility | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other (List in comments, please be specific): | | |

Comments: _____

- | | | | |
|-----------------------------|---|--|--|
| Special Needs | <input type="checkbox"/> Emotional/Behavioral | <input type="checkbox"/> Hearing/Speech | <input type="checkbox"/> Physical Mobility |
| Training/Experience: | <input type="checkbox"/> Medical Conditions | <input type="checkbox"/> MR/DD | <input type="checkbox"/> Visual |
| | <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Other (List in comments, please be specific): | |

Provider has had: _____

- Environment:**
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Field Trips | <input type="checkbox"/> Fenced Yard | <input type="checkbox"/> Pool/Waterfront | <input type="checkbox"/> Large Muscle Room |
| <input type="checkbox"/> No Pets | <input type="checkbox"/> Outdoor Pets Only | <input type="checkbox"/> Smoke Free | <input type="checkbox"/> Wheelchair Accessible |
| <input type="checkbox"/> Non-Smoking During Care Hours | | | |

- Meals:**
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Breakfast | <input type="checkbox"/> Morning Snack | <input type="checkbox"/> Lunch | <input type="checkbox"/> Afternoon Snack |
| <input type="checkbox"/> Dinner | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Parent Provided | |
| <input type="checkbox"/> USDA - If Yes, Name of USDA Food Sponsor: _____ | | | |

- Safety:**
- | | |
|--|--|
| <input type="checkbox"/> CPR Current Within 2 Yrs. | <input type="checkbox"/> First Aid Training |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Liability Insurance |

Census Bureau Demographics:

Is this person Spanish/Hispanic/Latino?

- No, Not Spanish/Hispanic/Latino
 Yes, Puerto Rican
 Yes, Other (print) _____
 Yes, Mexican, Mexican Am., Chicano
 Yes, Cuban

What is this person's race?

- White
 Black/African Am./Negro
 American Indian or Alaska Native (print tribe) _____
 Asian Indian
 Native Hawaiian
 Chinese
 Filipino
 Japanese
 Vietnamese
 Other Asian (print race) _____
 Guamanian or Chamorro
 Samoan
 Other Pacific Islander (print race) _____
 Other Race (print race) _____

What is this person's ancestry or ethnic origin? _____ (i.e. Italian, Jamaican, African Am, Cambodian, Haitian, Korean)

Does this person speak a language other than English at home?
 Yes
 No
 What language? _____

How well do the persons speak English?
 Very Well
 Well
 Not Well
 Not At All

Update Completed by: _____

Date Completed: _____ **Best time to reach:** _____ **am/pm**

Please mail or fax the completed form to **Starting Point, 4600 Euclid Avenue, Suite 500, Cleveland, OH 44103**

216-575-0102 (Fax). This form is also available online at www.starting-point.org. If you prefer to speak with someone directly, contact us at **216-575-0061** or **1-800-880-0971**. Thank you!

For Office Use Only

Staff Name: _____ **Program ID No.** _____

Date Received: _____ **Date Entered:** _____